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LONG TERM CARE BED NEED:

1987 - 1990

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EXECUTIVE OFFICE OF HUMAN SERVICES
November 17, 1987

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EXECUTIVE SUMMARY

Background

The increasing demand for long term care institutional services due to the growing number of elderly and the inappropriate utilization and distribution of existing long term care services have resulted in the need to review the current Long Term Care Standards and Criteria. The Executive Office of Human Services, Office of Health Policy began this review in March 1986.

A wide variety of issues and concerns were examined. These included appropriateness of care of patients receiving public assistance, the increasingly ill and dependent patients in nursing homes, our ability to care for a more dependent population at home and changes in public and private financing of care. In addition, issues specific to the D.o.N. program were addressed and these findings incorporated into the recommendations. These included comparability, special populations, service areas, data, Medicaid utilization and BANYL beds.

New beds are currently being added to the supply at the rate of 101.2 per month, an increase from the 1984 mark of 60.7 beds per month. This is a 59.5% increase in the rate of new supply coming on line and reflects well on the Commonwealth's committment to pay for its share of patient days. The recommendations in this report continue on that committment.

Recommendations and Priorities

The Executive Office of Human Services recommends that more Level I/II and III nursing home beds be added to the system. Under the current guidelines, the Commonwealth can expect 8,559 more nursing home beds by 1990. This report calls for an additional 3,236 beds above the current guidelines resulting in a 1990 goal of 11,795 more nursing home beds.
This would result, if all the beds are put on line by 1990, in 70.61 beds per 1000 elderly, a 19% increase from the current operating level and a major increase from the previously established 1990 target of 62.86 beds per 1000 elderly adopted in the 1983-1990 State Health Plan.

The recommendations in this report begin to refocus how these additional beds are added to the system.

The first aspect of this change is a general access measure designed to quicken the process for upgrading levels of care, adding up to ten Level I/II beds, and re-licensing medical/surgical beds to Level I/II. These measures affect all areas of the state.

The second major change implements a targetting system that places scarce resources in areas with the most need for beds as well as areas experiencing particular problems with displacement of inpatient capacity due to in-migration, Medicaid utilization, heavy care patients or a high number of Administratively Necessary Days in relation to available beds.

In addition to this there are recommendations that address the use of state-owned land, local zoning practices that may prevent siting of new homes, replacement of existing facilities, special populations, planning areas and BANYL beds.

SUMMARY OF RECOMMENDATIONS

1. The Determination of Need process for reviewing and approving new nursing home beds should be changed to reflect a pro-active bid approach which examines availability, accessibility, and continuity-of-care of nursing home beds in an area.

2. The application filing cycle should be changed to once-a-year.

3. Level III beds should be added to the system only as part of new construction for a free-standing Level I/II facility and then only in 41 bed units.

4. The following exemptions to the bed need criteria (but not to D.o.N.) should be allowed if the cost is under $600,000.00:

    1. A one time 10 bed increase for SNF beds only if the addition results in a coherent 41 bed unit.
    2. Upgrades to SNF beds from ICF or Rest Home.
    3. Relicensing from Medical/Surgical or Chronic to SNF.

5. All new Level I/II beds should be certified for Medicare.

6. New beds for special populations should be based on clinical criteria only.

7. Standards and Criteria for determining need should be based on the twenty-six Health Systems Agency subareas.

8. The Executive Office of Human Services, in conjunction with other state agencies, should research whether anti-nursing home zoning exists(analogous to anti-public housing zoning) and make recommendations to correct any problems.

9. The Executive Office of Human Services should submit legislation mandating that the set-aside of surplus state land for nursing home construction be a priority.

10. Boston HSA, through its contract with the state, should act as a broker with state, municipal and and non-profit entities for the purposes of developing nursing home projects in the City of Boston.

11. The Department of Public Health should publish once a year a status report of all Beds Approved but Not Yet Licensed in major newspapers.

12. Replacement of Level I/II and III beds only, on the original site, should be allowed regardless of unit projections for that area.

13. The general Medicaid condition on new bed approvals should be changed to reflect admission practices as listed below:

    1. Medicaid patients should be admitted at a rate of 67.72% for the first year.
    2. Medicaid patients should be admitted at a rate equal to one-half the difference between the area average and the state, or the state average, whichever is higher.

I. INTRODUCTION

The increasing demand for long term care institutional services due to the growing number of elderly and the inappropriate utilization and distribution of existing LTC services have resulted in the need to review the current Long Term Care Standards and Criteria. The methodology for establishing the desired number of long term care beds was developed in the mid seventies. The policy, which was adopted in 1978 and revised in 1983, has served its purpose well in the last several years but radical changes in the orientation and provision of long term care are unfolding which should be reflected in updated standards and criteria. The Executive Office of Human Services, Office of Health Policy began this review in March 1986. This report presents the findings and recommendations.

The knowledge and experience with regard to the delivery of nursing home services, along with a much changed non-institutional sector, has created a new atmosphere in which to consider how we review and approve applications for nursing home beds. Every effort has been extended to go beyond examining the mere calculation of bed need to consider what standards and criteria can be developed that will positively affect the kind of growth in institutional care that will most benefit consumers and taxpayers.

Standards and criteria are only one factor which affects the availability and use of long term care beds. Reimbursement, case management, and alternative services are among other factors which affect access and utilization. The long term care bed need standards and criteria proposed here are simply one device that contributes to an overall solution.

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A. Long Term Care Bed Need Standards and Criteria Advisory Group

The Advisory Group was formed to guide this Office in the development of the recommendations contained in this report. The Group has met over fouteen times during the course of formulating this Report. The members of the group include:

Claudia Harrison	Mass. Federation of Nursing Homes
Steve Garfinkle	" "
Paul Lanzikos	Beverly Hospital
Marianne Duddy	Living Is For the Elderly(LIFE)
Joseph Lydon	M.A.C.H.A
Gail Jones	A.M.N.H.A
Dotty Mooney	Mass. Hospital Association
Brandon Delaney	HSA I
Mara Yerow	HSA II
Gail Morley	" "
Ed Perregaux	HSA III
Paul Guerard	HSA IV
Joanne Agababian	HSA V
Ed Marakovitz	HSA VI
Judy Sklare	Administration and Finance
Larry Levitt	" "
Lois Simon	Dept. of Public Welfare
Fred Hooven	" "
David Cavalier	Dept. of Public Health
Paul Dreyer	" "
Randall Rucker	" "
Gene Chavez	" "
Susan Flanagan	Rate Setting Commission
Betty Lykins	Executive Office of Elder Affairs
Susan McDonough	" "
Ginny Felice	Commission on Elderly Health Care
Wayne Szretter	U.S. Veterans Administration

The scope of the Advisory Group's role was to assist in the development of recommendations concerning the following:

1. the number and type of nursing home beds needed in the Commonwealth.
2. the appropriate distribution of nursing home beds across the state.
3. the standards and criteria by which applications for new nursing home beds will be considered.
4. the process by which determinations of need for new nursing home beds will be made.

The principles that guided the Advisory Group were:

1. access to all levels of care can best be achieved by assuring that patients are served in the least restrictive setting possible.
2. costs can best be managed by assuring that patients are institutionalized in the least restrictive setting necessary to serve them.
3. expansion should occur within existing capacity when feasible.

II. THE CURRENT BED NEED FORMULA

A. Background

In 1970 a survey of nursing homes led the Commonwealth to conclude that 64% of the patients in nursing homes did not need the level of care which the nursing homes were required, by regulation, to provide. The survey also estimated that 14% of all nursing home residents did not need to be in nursing homes at all.

These findings helped set the stage for developing a needs based formula, consistent with the National Health Planning Act requirements, and based on surveys conducted in 1974 and 1975. These surveys included needs assessments on samples of patients in chronic disease and rehabilitation hospitals, SNF's, ICF's, rest homes and the community. The initial findings resulted in recommending a nearly 80% reduction in CD/RH beds, an increase by more than 50% of SNF beds and a decrease in ICF beds by one-third. The overall effect on the number of beds amounted to more than a 10% reduction, which was to be compensated for by an increase in community placements.

The methodology also included provision for varying the target per thousand elderly among the 38 long term care areas, depending upon the difference in the age mix of the area. Between 1978 and 1983 the age adjustment, or regional modifier, was calculated using a multiple regression formula which used the proportion of elderly 75+ as the independent variable. In 1983 this was changed to a straight bed to population ratio, utilizing the 65 to 74 year olds as one group and the 75+ as the other group.

B. The Bed Need Formula and Policy

The bed need formula is a reflection of the state's policy for long term care. Its purpose is to determine the number and type of nursing and rest home beds needed in the Commonwealth, as well as their appropriate distribution. The bed need formula, as currently devised, restricts the growth of level III nursing home beds, allows growth of Level I/II beds and caps the supply of chronic hospital beds.

In this manner, the formula has implemented policy by balancing the need for access into specific levels of beds while maintaining constraints on the supply of other types of beds.

Current long term care policy states that access to all levels of care can best be achieved by assuring that patients are served in the least restrictive setting possible. This can help make available needed institutional resources that are in high demand and which will have a positive impact across the entire system. Costs can best be managed by assuring that patients are institutionalized in the least restrictive setting necessary to best serve them. Similarly, assuring that patients are in the appropriate setting, or conversely, that the setting the patient is in is properly licensed and reimbursed for the patient's needs will also enhance access and cost containment.

Table 1, on the next page, displays the trends in Level I/II and III nursing home beds per 1000 elderly from 1974 to 1987 and projected to 1990. Additionally, Table 1 lists the target ratio of beds desired for 1990 established in the 1983-1990 State Health Plan.

The number of Level I/II and III beds per 1000 elderly has declined from 65.66 beds in 1974 to 59.37 beds in 1987. The next column in Table 1 indicates that if all BANYL beds that were approved were on-line the bed to population ratio would have been 66.02 beds per 1000 elderly, just slightly above historical supply and significantly above the State Health Plan target of 62.86. It is fair to assert that if nursing home supply were at this level, much of the debate concerning access would not be occuring today.

The column in Table 1 labled "1990 old and new targets" illustrates the effect that approval of the recommendations contained in this report will have. This is a major increase from historical levels as well as previously established targets. The reason for the decline in the bed to population ratio is attributable to the fact that Level I/II beds have not been coming on-line as quickly as anticipated. Despite a growth rate between 1974 and 1987 of 20.3 percent this has not been enough. This is not for lack of approvals of new beds by the state. As Table 1 indicates, when the 1987 supply includes BANYLS the growth in level I/II is 41.1%, enough to compensate for the changes in Level III and the growth in the elderly population.

Every indication is that the rate of new supply is increasing. The number of new beds coming on line in 1984 stood at 60.7 per month. For the first six months of 1987 this figure increased to 101.2 per month. This was a consistent increase over the last three years that will have a positive effect on supply.

Table 1. Trends in Level I/II and III Beds per 1000 Elderly 1974-1987 and projected to 1990.

	1974 supply	1980 supply	1987 supply	1987 supply &BANYL	1990 old&new targets	1990 SHP target
I/II	22.43	27.64	26.99	31.66	34.87	30.14
III	43.23	37.93	32.38	34.36	35.74	32.71
Tot	65.66	65.57	59.37	66.02	70.61	62.86

III. CRITICAL ASSUMPTIONS AND ISSUES

A. Assumptions

Essential to understanding the recommendations in this report is a review of the assumptions upon which these recommendations are based. This section discusses these assumptions.

1. All patients receiving public assistance are appropriately placed.

Previous formulations of the bed need methodology have operated on the assumption that a portion of patients in nursing homes and chronic hospitals either did not belong there at all or were mis-leveled. The general consensus of the Task Forces examining these issues was that change needed to made.

Since that time the state has increased its ability to manage decisions concerning the type of patient that enters a nursing home. Through the Long Term Care Connection, a program conducted by the Department of Public Welfare, every applicant for public assistance seeking a nursing home placement is screened and a determination is made whether a non-institutional placement can be developed. This activity, coupled with a much more developed non-institutional delivery system, has increased the state's ability to place patients in a community environment.

Demographic changes continue at such a rate, however, that the types of patients entering nursing homes are much more dependent in all activities of daily living. Because of this and the factors cited above, publicly assisted indivduals are appropriately placed.

2. Patients in institutions will become more dependent and disabled over time.

It is a fact that the patients in nursing homes are a much more disabled, ill and dependent population then they were ten years ago. This is especially true for skilled nursing care as the following information makes clear:

Table 2. Percent of Publicly Assisted SNF Patients Totally Dependent for 0-6 ADLs. 1975-1985.

ADLs	1975	1985
0	34%	15%
1-3	34%	34%
4-6	32%	51%

While the changes for SNF patients are dramatic, the same cannot be said for the Level III patients. The table below examines this issue.

Table 3. Percent of Publicly Assisted ICF Patients Totally Dependent for 0-6 ADLs. 1975-1985

ADL	1975	1986
0	71%	69%
1-3	20%	23%
4-6	9%	8%

This information is corroborated by two significant trends. A comparison of nursing home patient level of care at time of admission taken from the 1978 and 1986 patient origin studies indicate that Level I/II admissions grew by 24.3% while Level III patient admissions only grew by 16.3%. When this same trend is examined by current level of care the patient origin studies indicate that the number of Level I/II patients grew by 59.4% while Level III stayed flat at less than one percent.

Taken from another perspective, between 1982 and 1984 Level I/II patient days increased by 9.7% and beds increased by 9.8% maintaining occupancies of 94.4% and 94.2% in those years. By contrast, Level III patient days grew by 1.4%, beds declined by 1.4% and occupancy changed from 95% to 96%.

This data indicates that new standards and criteria should clearly and directly be oriented towards the development of Level I/II skilled nursing beds. Level III beds should be built only as part of a free-standing nursing home and only if desired by the developer. They should be built to the physical standards of skilled nursing units so that they can be easily upgraded. In this case this would be in 41 bed units. New Level IV beds would not be allowed under this proposal.

3. The state's ability to care for a more dependent population in the community will increase over time.

Development by the Executive Office of Elder Affairs of a targeting strategy has already begun to shift the type of caseload being cared for by the home care corporations. Preliminary data from the community care connection program and the HMO/HCC program indicate that patient care

in these programs are approaching comparability with nursing home patients in terms of levels of disability. A comparison between 1986 data for these programs and 1985 DPH data on ADLs of nursing home patients in SNF and ICF reveals that the patients in EOEA's Functional Impairment Level One exceed in dependency in Bathing, Dressing, Eating, Bladder Function and Mobility those patients in ICFs and are approaching comparability with those patients in SNF. While this data is preliminary it positively demonstrates our ability to provide services to a very functionally impaired clientele in the community.

4. The ability of the elderly to finance their own care will increase over time.

The elderly population has benefited from the inflation of the seventies and a heated real estate market in the eighties. These two forces have combined to make their retirement benefits, savings and housing assets worth a great deal. This has enabled many elderly to finance a good portion of their care when needed.

According to the U.S. Bureau of the Census's 1984 data for Household Wealth and Asset Ownership (Household Economic Studies Series P-70, No. 7) net worth increased from $5,760 for the youngest households to $73,660 for households in the 55-to-64 year-old category and then declined to $55,180 for the oldest group (75 years and over). There was no evidence that net worth decreased for the oldest age groups within any income group. The older group had a net worth approximately ten times that of the younger group ($55,180 versus $5,760). When home equities were excluded, the oldest group had a net worth approximately six times that of the youngest group ($17,030 versus $2,970).

The data presented in table 4 indicates that growth in Level II and III days has come primarily from the private sector. Furthermore, the activity being generated by insurance companies to develop and sell long term care insurance will also grow and create third party funding for nursing homes. The insurance companies have noted the increased assets and discretionary dollars available to the elderly and, coupled with a growing demand for long term care services, are rapidly organizing to fill this gap.

Table 4. Changes in Level II/III Patient Days-1982-84

Payor	1982	1984	% Change
Private	4,246,341	4,488,410	5.7
Medicaid	10,432,593	10,471,570	.37
Total	14,678,934	14,959,980	1.91

The entrance to any degree of private dollars into the long term care market will have a significant effect on the type and nature of services to be offered. It can be expected that the elderly who are making these purchases will desire a much higher quality product in terms of services offered, amenities and aesthetics than is currently available. They will demand types of services that are only now emerging.

5. Public reimbursement for nursing homes will be on a prospective, case-mix system within the next five years.

The Commonwealth has received a grant to test the implementation of a reimbursement system for nursing home patients that bases payment on the patients level of dependence and illness rather than on average costs of the facility. Furthermore, this system will set payment in advance so that the provider has a predictable budget for that year. Currently, we pay for publicly assisted patients in a way that is always catching up to the costs incurred in providing services.

This system, when fully implemented, will likely speed the entrance of so-called heavy care patients into nursing homes. The provider will no longer have an incentive to balance the case mix of his facility so that he can average out his costs. This system will base payment on the patient's needs. Furthermore, under a prospective system, both the provider and payor of care will have a better capability to predict in advance the impact of costs. This will allow the state a greater abilty to control the costs of care for nursing homes, thus relieving the bed need methodology from its function as a cost containment device.

6. Medicaid eligibilty is not expected to change.

Massachusetts offers a full range of long term care services for the Medicaid eligible individual. Discussions over the years have indicated that eligibility for these services is not expected to change from the level that they are now set. Medicaid will continue to be a major payor of long term care in this state.

B. Issues

Several issues that affect how the need for new beds is determined were reviewed. These are discussed below.

1. Comparability

Determining the comparability of applications remains a vexing process-problem for analysts as well as applicants. As it stands now, comparability can be determined across the three filing periods in the filing year. This can lead applicants to wait to see what major applications have been filed in a particular period, file in the following filing period and low-ball the cost to gain favorable status. The recommendations in this Report require that major applications file once a year. Projects that intend to add up to ten Level I/II beds for one time only, upgrade levels of care to Level I/II, relicense medical/surgical beds or chronic hospital beds to Level I/II and cost under $600,000.00 can file at any time..

2. Treatment

Treatment of patients in long term care facilities and in the community has been undergoing tremendous change and is likely to continue changing as new or alternative services are developed. Massachusetts has experienced an explosion of non-institutional services and it is still not clear today to what degree these services can be substituted for nursing home services. In addition to these, new and innovative programs to treat conditions like Alzheimer's disease and mental or behavioral disorders are creating a range of treatment options in this field.

Currently, special populations are distinguished by social or cultural criteria. It is clear that as changes occur in the treatment of patients combined with the lack of approvals or applications based on the old criteria, the old criteria is no longer valid.

3. Long Term Care Service Areas

Nursing home bed need is currently calculated using thirty-eight service areas across the state. These service areas do not conform in all cases with the Long Term Care Connection program areas or the home-care corporation areas. This makes planning for the delivery of services, and gathering and analyzing data very difficult. At the very least, planning and service areas should be uniform. The recently completed patient origin study will be able to provide a sound basis for re-drawing these boundaries. The data not only includes the place of origin of the patient but also the residence of the most responsible relative of the patient. Inclusion of this factor should have a significant effect on the nature of the areas. Until this data is analyzed and agreement on the boundaries reached, the HSA sub-areas appear to be the most reasonable boundaries to use. This will reduce the number of planning areas from 38 to 26.

4. Area Modifier

The original and the revised versions of the bed need methodology employed techniques to take into account the age mix of an area designed to target beds to those over the age of seventy-five. It is a fact that the older a person the more likely that a person will need a bed. All analysis indicates that the eighty-five and over group is the most critical one in this regard. The previous versions of the bed need methodolgy were not able to accomodate this age cohort because population projections were not available. While the U.Mass MISER project has developed projections for this age group, technical problems exist in terms of their validity at the town and city level that need to be resolved. Until then use of the 1990 DPH population projections will continue based on the following age cohorts: 0-64, 65-74, and 75+.

5. Data

The availability of sound data continues to be problematic. Although the range and sophistication of the information available has increased, there still is a problem obtaining data that can be analyzed across areas. This hinders our ability to analyze changes in service delivery in any kind of uniform manner. At a minimum, the Dept. of Public Health should replicate the patient origin study every two years so that a solid and consistent base of information on nursing home utilization can be obtained.

6. Access

As previously discussed, occupancy rates have risen to such a point that access to beds is difficult. This problem is considerable for patients whose payment source upon admission is Medicaid. This access problem can be addressed by Determination of Need in two ways. The first is to provide for more new beds by allowing each nursing home to upgrade and add on a limited number of nursing home beds to their facility. In addition, hospitals should be allowed to re-license medical/surgical beds to skilled beds regardless of the area need as long as they conform to all the regulations that govern nursing homes.

The second way to address the access problem is to specifically detail the types of applications for new construction and major additions expected for certain areas.

7. Beds Approved But Not Yet Licensed

Beds Approved But Not Yet Licensed (BANYL) are those beds that have been approved by the Public Health Council for construction, conversion or upgrading. They remain in BANYL status until they receive a license to operate or the D.o.N. is revoked by the Public Health Council. With a license the beds can be used to care for patients. BANYL beds are a necessary

part of the system and is similar to construction companies that receive permits to build houses but cannot be occupied until they are built and have received certificates of occupancy.

Much attention has always been focused on the issue of BANYL beds. By law, construction must be started within two years of D.o.N. approval. In fact, the track record for opening new beds is much better than what the law allows. An analysis of the last eight new homes opened reveals that the average time from PHC approval to licensing of the first twenty beds is 25 months with a range of 16 to 38 months. It took an average of 14.3 months to receive approval from date of application for these eight projects with a range of 9 to 20 months.

An analysis of all BANYL beds as of April 29, 1987 provided by the Determination of Need program indicates that average approval time was 15.4 months. This figure drops to 12.9 months when comparable and special applications are factored out. Of the 6,369 beds of all levels in BANYL status at the time only 5% could be documented as not having achieved significant progress towards construction at the end of two years. Of those that were two years old and not under construction, all had requested extensions for completion. Current policy is to grant these extensions if documentation is provided showing legitimate delays. This is generally to ensure an adequate supply of beds to the citizens of the Commonwealth.

Despite this, it has been expressed by members of the Advisory Group that zoning restrictions and lack of land is continuing to inhibit construction of beds. To address this, this Report is recommending that surplused state-owned land be given a high priority for nursing home construction especially in the City of Boston and that EOHS examine zoning problems.

It appears that one of the biggest problems with BANYL beds is community perception of no progress. In order to address this, and to make applicants publicly accountable after a D.o.N. is approved, this Report is recommending that a BANYL status report be published once a year in major newspapers across the state.

8. Medicaid Utilization

The current practice of the Public Health Council in regard to Medicaid utilization is to place a condition on all approvals of new beds that requires 60% of first year admissions be Medicaid and that the home maintain a Medicaid census equal to the area average in which the nursing home is located. This condition is an attempt to prevent discrimination against Medicaid patients when seeking admission into a home. This condition uses current census as a baseline. This may not accurately reflect admission practices.

Data from the 1986 patient origin study (listed in the spreadsheet attached to this Report) provides an indication of the extent to which people on Medicaid seeking direct admission to a nursing home stay in their area of origin. Accordingly, 67.72% of Medicaid patients seeking admission in their area stayed in their area of origin on the average for the 26 areas for Level I/II patients. This rate varied from a high of 97.06% in New Bedford to a low of 26.32% in the Medford/Malden/Everett area.

This Report addresses this issue in two ways. First, in those areas where the rate of "Medicaid Stayers" is lower than the state average minus one standard deviation, a special condition is cited. This condition allots an extra 41 beds to that area for the specific purpose of serving Medicaid patients.

The second way in which this issue is addressed is to change the general Medicaid condition to require that first year admissions of any new beds, whether gained through construction, upgrading, add-on, or re-licensing, (except as part of a special condition) be admitted at the rate of 67.72% and then maintain an admission rate equal to one-half the difference between the area average and the state average or the state average if it is higher.

IV. THE EXPERIENCE IN OTHER STATES

The experience of other states is varied. Some are allowing the system to grow unfettered while others have placed complete moratoriums on growth.

Arizona and Utah have chosen to allow development of new nursing homes without any controls on growth. As expected, this has resulted in a tremendous growth in new facilities including some failures of new nursing homes. Texas, another state which has sunsetted their C.o.N. program, allows growth to occur but has placed a moratorium on new Medicaid contracts. This is, in effect, a moratorium. There is currently an 80% occupancy rate in Texas. California has sunseted its C.o.N. law this year.

Many states have chosen to place a moratorium on new nursing home beds. This is usually in response to efforts to develop a more cohesive, single-entry point, non-institutional system. A 1984 survey indicated that sixteen states had moratoriums. A recent check indicates that some states have now lifted their moratoriums. Finally, the remainder of the states have chosen to continue approval systems similar to the current Massachusetts system.

The lack of any uniform action among the states reflects the policy flux in which long term care finds itself both nationally and locally. There is no particular guidance that can be derived from the actions and experiences of other states.

V. RECOMMENDATIONS

1. The Determination of Need process for reviewing and approving new nursing home beds should be changed to reflect a pro-active bid approach which examines availability, accessibility, and continuity-of-care of nursing home beds in an area.

Discussion

This change in the standards and criteria re-orients the Determination of Need process from a reactive-oriented system to a pro-active development program that seeks to identify the need for very specific applications in areas of the state that are in the most need. The current process merely indicates a need for beds in an area and has no basis for identifying who or for what the beds should be used. The new system would specifically indicate the type of application we are seeking. As an example, we could issue invitations for applications that network hospitals with high AND problems or we could call for applications that specifically address issues of Medicaid accessibility to beds. Such a system offers tremendous flexibility to do creative programming of this nature.

The important point of such a change is that we begin to move away from the question of how many beds to the real issues of who the new beds will serve and their role in the community. This positive approach best utilizes the state's resources to help those areas that have the most pressing needs. Using preset criteria, specifications for applications will be issued and providers will be invited to submit proposals.

2. The application filing cycle should be changed to once-a-year.

Discussion

Currently we have a three-time-a-year filing cycle for projects. Major projects can only be submitted in September and all others in January, May or September. The law should be changed to have only one filing cycle because the process to set out invitations would require at least six months to complete. It would also be necessary to circulate initial recommendations for a two month period in order to receive local comment and make adjustments. A once-a-year filing cycle for major projects as proposed in this report would accomodate the timely processing of applications. This is a necessary administrative change to incorporate bid elements into the D.o.N. system for major projects.

3. Level III beds should be added to the system only as part of new construction for a free-standing Level I/II facility of at least 82 beds and then only in 41 bed units.

Discussion

All the data indicate that the need for Intermediate Care Nursing Home beds (Level III) is waning. Furthermore, current regulatory and reimbursement initiatives are moving away from the level of care system. It is argued, however, that as long as the level-of-care system is in place there will be a need for Level III beds in a facility to allow for continuity of patient care. This can be accomodated by a procedure that allows for the addition of these beds only in conjunction with the construction of new free-standing Level I/II nursing homes.

4. The following exemptions to the bed need criteria should be allowed:

1. **A one time 10 bed increase for SNF beds only if the addition results in a coherent 41 bed unit.**
2. **Upgrades to SNF beds from ICF or Rest Home**
3. **Relicensing from Medical/Surgical or Chronic to SNF**

Discussion

Any change under the exemptions listed above must be under the current $600,000.00 capital cost threshhold in order to be allowed. Furthermore, any changes in hospital beds to nursing home beds must comply with all rules and regulations for the licensing and reimbursement of nursing homes including paricipation in the the Ombudsman Program. A form would be required with assurances stating that the facility will comply with the Medicaid condition, life safety code and physical environment requirements and cost. Massachusetts regulations 105 CMR 151.021 and 105 CMR 151.300(A) stipulate that Skilled Nursing beds must be built in 41 bed unit sizes. This recommendation does not contemplate changing from that standard.

5. All new Level I/II beds should be certified for Medicare.

Discussion

Data indicates that the case load in nursing homes is becoming increasingly frail and ill and moving away from the custodial care requirements of the past. Medicare does not pay for custodial care. It is apparent that many patients in nursing homes could benefit from the rehabilitative orientation of services payable under Medicare. By requiring that all new Level I/II units be certified, the likelihood of eligible patients receiving this care will increase, especially with the incentives to discharge earlier from the hospital under the Medicare PPS program.

6. New beds for special populations should be based on clinical criteria only.

Discussion

Treatment of patients in long term care facilities and in the community has been undergoing tremendous change and is likely to continue changing as new or alternative services are developed. Medical technology has advanced to the point where many lives that were previously lost are now being maintained. Society has an obligation to provide appropriate services to these patients. Increasingly, the service system for these patients is long term care whether institutional or non-institutional. New and innovative programs to treat special populations are pushing the frontiers of treatment options.

An inter-agency group should be formed to create guidelines for the development of beds for clinical special populations. Concept papers would be submitted describing the scope and practice of caring for these patients in and out of the institutiion. Concept papers would be based on preset criteria that at a minimum would describe the incidence and prevalence of the disorder or illness, current treatment practices, expected need for services and national and international experience. Submission of concept papers would not imply development of a project.

7. **Standards and Criteria for determining need should be based on the twenty-six Health Systems Agency subareas.**

Discussion

Nursing home bed need is currently calculated using thirty-eight service areas across the state. These service areas do not conform in all cases with the Long Term Care Connection program areas or the home-care corporation areas. This makes planning for the delivery of services, and gathering and analyzing data very difficult. At the very least, planning and service areas should be uniform. The recently completed patient origin study will be able to provide a sound basis for re-drawing these boundaries. The data not only includes the place of origin of the patient but also the residence of the most responsible relative of the patient. Inclusion of this factor should have a significant effect on the nature of the areas. Until this data is analyzed and agreement on the boundaries reached, the HSA sub-areas appear to be the most reasonable boundaries to use. This will reduce the number of planning areas from 38 to 26.

8. **The Executive Office of Human Services, in conjunction with other state agencies, should research whether anti-nursing home zoning exists(analogous to anti-public housing zoning) and make recommendations to correct any problems.**

Discussion

It has been stated in Advisory Group discussions that building new nursing homes is difficult because most land that is potentially usable is either not zoned for use or subject to many restrictions. While there is no documentation to support these statements it is important enough of an issue to pursue to determine the extent of "snob" zoning that exists in the Commonwealth in respect to nursing homes.

9. **The Executive Office of Human Services should submit legislation mandating the set-aside of surplus state land for nursing home construction be a priority.**

Discussion

Regardless of the outcome of the recommendation above, the need for nursing home beds is serious enough that the Commonwealth should pursue prioritizing the set-aside of portions of surplus state land dedicated to nursing home construction by non-profit entities. Already many portions of surplus state land have been ear-marked for low income housing, job production and the needs of the mentally ill. Currently the Legislature is debating the surplussing of large portions of the Boston State Hospital campus for development of low income housing and commercial activities. Use of some of this property for the construction of a nursing home would benefit that community.

10. Boston HSA, through its contract with the state, should act as a broker with state, municipal and and non-profit entities for the purposes of developing nursing home projects in the City of Boston.

Discussion

Essential to fulfilling the needs of the City of Boston, which this report identifies as needing the most beds, is an independent agency that can act as a development broker and provide technical assistance to those non-profit agencies desiring to develop competitive proposals for construction of nursing home beds in the City. The Boston HSA, through its contract with the commonwealth, can fulfill this function. This agency has the necessary expertise and relationships with the City and state to assess the availability of public land and to make the connections with the non-profit providers wishing to develop new beds.

11. The Department of Public Health should publish once a year a status report of all Beds Approved but Not Yet Licensed in major newspapers.

Discussion

This recommendation is designed to bring heightened community awareness regarding the status of approved nursing home projects. Much attention has been given to the problem of so-called BANYL beds (Beds Approved but Not Yet Licensed). Once a Determination of Need application is approved by the Public Health Council, two years is allowed for the applicant to start construction. There can be a variety of situations in which the two year limit is passed. In these cases, requests for extensions are brought to the Council for approval. These requests are granted if the applicant has sufficiently made the case that the extension is justified. In other cases, the two year time limit has passed and the applicant has not made efforts to bring the project to completion. In these circumstances, the D.oN. compliance staff will recommend revokation of the project.

BANYL beds are also addressed in this report by limiting development of new beds to those areas that have less than ten percent of their supply in BANYL status. The current area average is twenty-two percent. By limiting development of new beds to those areas that have ten percent or less of their supply in BANYL status, attention will be naturally focused on timely construction of new projects.

12. One on one replacement ofLevel I/II and III beds only on the original site, with provisions to continue care of current patients in the replacement beds, should be allowed regardless of unit projections for that area.

Discussion

This recommendation applies to Level I/II and III nursing home beds only. It should be clear that facilities wishing to replace beds may also seek to utilize the add-on provision as well as apply for additional units if units are projected for the area.

13. The general Medicaid condition on new bed approvals should be changed to reflect admission practices as listed below:

1. **Medicaid patients should be admitted at a rate of 67.72% for the first year.**
2. **Medicaid patients should be admitted at a rate equal to one-half the difference between the area average for Medicaid stayers and the state average plus the state average, or the state average, whichever is higher.**

Discussion

This condition applies to all new beds approved as a result of the ten bed add-on, upgrades, relicensing or new unit additions including any Level III beds. This condition does not apply to beds approved as aresult of special conditions except if Level III beds are granted on a special condition approval.